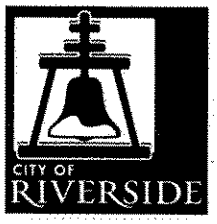

WORKERS' COMPENSATION OFFICE
3780 Market Street
Riverside CA 92501

EMPLOYEE NAME:_____ **CLAIM NUMBER:**_____

ADDRESS:_____ **CITY:**_____ **ZIP CODE**_____

DATE OF INJURY:_____ **WORK PHONE:**_____ **HOME PHONE:**_____

Under California Workers' Compensation Law, you are entitled to reimbursement of mileage costs at the rate of 34 cents/mile, to and from medical appointments or treatment for your industrial injury or illness. Please use this form to keep track of your mileage and any related medical expenses and submit it to the Workers' Compensation office for reimbursement.

DATE	TO	FROM	#MILES	RELATED EXPENSE	$AMOUNT

THIS IS A TRUE ACCOUNT OF MY MILEAGE. SIGNED:_____ DATE:_____[1]

[1]

REQUEST TO WITHDRAW INDUSTRIAL CLAIM FOR BENEFIT

CLAIMANT:

Name: _____

Address: _____

Social Security #: _____

Date of Birth: _____

Employer: _____

I hereby request to withdraw any claim for Workers' Compensation benefits as a result of a work related injury claim filed on _____, and alleging to have occurred on/about _____, and claiming the following injuries:

By requesting this claim be dismissed, I agree to hold _____ harmless from any liability related to this claim.

I hereby swear under penalty of perjury of the laws of the State of California that this waiver is of my request and no threats or promises have been made to induce me to sign this waiver. The facts outlined are true to the best of my knowledge and belief.

Signature: _____

Signed this _____ day of _____, 19__, at _____, California.

Witness: _____

KAISER PERMANENTE®
Kaiser Foundation Hospitals
The Permanente Medical Group, Inc

Copies of this signed authorization will be considered as valid as the original

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

IMPRINT AREA

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

I hereby authorize _____
NAME OF DISCLOSING PARTY

_____
ADDRESS

_____
CITY STATE ZIP

to disclose to _____
NAME OF RECEIVING PARTY

_____
ADDRESS

_____
CITY STATE ZIP

records and information pertaining to

_____ _____ _____
NAME OF PATIENT (LIST OTHER NAMES USED) MEDICAL RECORD NUMBER DATE OF BIRTH

_____ _____
ADDRESS TELEPHONE NUMBER

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ DATE or for one year from the date of signature

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now an the disclosure of information by the disclosing party. My written revocation will be effective upon receip but will not be effective to the extent that the Requester or others have acted in reliance upon th Authorization

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless anoth authorization is obtained from me or unless such use or disclosure is specifically required or permitted by la

SPECIFY RECORDS: Check the box and initial to specify which type of information is to be disclosed

☐ **MEDICAL INFORMATION** _____ INITIAL

☐ **PSYCHIATRIC INFORMATION**
_____ SIGNATURE _____ DATE

☐ **DRUG/ALCOHOL INFORMATION**
_____ SIGNATURE _____ DATE

☐ **RESULTS OF AN HIV BLOOD TEST**
_____ SIGNATURE _____ DATE

☐ **OTHER HEALTH INFORMATION** _____ (specify below)

Specify the records to be disclosed: _____

_____

_____

_____

The requester may use the health information authorized on this form for the following purposes only: _____

_____

_____

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION
HEALTH INFORMATION AND/OR EMPLOYMENT RECORDS

A copy of this authorization will be considered as valid as the original.
Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

I hereby authorize: _____
Name of Disclosing Party

_____
Address

_____
City State Zip Code

To disclose to: _____
Name of Receiving Party

_____
Address

_____
City State Zip Code

Records and Information pertaining to

_____ _____ _____
Name of Patient (list other names used) Medical Records # Date of Birth

_____ _____
Address Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until _____(date) Or for one year from the date of signature.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY RECORDS:

☐ Medical Information _____ Initials

☐ Psychiatric Information

☐ Drug/Alcohol Information

_____ Signature Date

☐ Results of HIV Blood Test

_____ Signature Date

☐ Other Health Information (_____Specify below)

☐ Employment Records _____ Initials

Specify the records to be disclosed:

_____

_____

The requester may use the health information authorization on this form for the following purposes only:

_____

_____

Signature:_____ Date:_____